UnitedHealthcare

Options PPO/covered dental services

dental plan
P7502

	NON-ORTHODONTICS		ORTHODONTICS	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Individual Annual Calendar Year Deductible	$50	$50	$0	$0
Family Annual Calendar Year Deductible	$150	$150	$0	$0
Maximum *(the sum of all Network and Non-Network benefits will not exceed annual maximum)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year	$1000 per person per Lifetime	$1000 per person per Lifetime

New enrollee's waiting period:	
Annual deductible applies to preventive and diagnostic services	No (In Network) No (Out Network)
Annual deductible applies to orthodontic services	No
Orthodontic eligibility requirement	Child (up to age 19)

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs	100%	100%	Bite-wing: Limited to 1 series of films per Calendar Year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Lab and Other Diagnostic Tests	100%	100%	
PREVENTIVE SERVICES			
Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatment (Preventive)	100%	100%	Limited to Covered Persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to Covered Persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For Covered Persons under the age of 16 years, limited to 1 per consecutive 60 months.
BASIC SERVICES			
Restorations (Amalgams or Composite)	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services (incl. Emergency Treatment)	80%	80%	Palliative Treatment: Covered as a separate benefit only if no other service was done during the visit other than X-rays. General Anesthesia: When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
Oral Surgery (includes surgical extractions)	80%	80%	
Periodontics	80%	80%	Perio Surgery: Limited to 1 quadrant or site per consecutive 36 months per surgical area. Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months. Periodontal Maintenance: Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement
Endodontics	80%	80%	
MAJOR SERVICES			
Inlays/Onlays/Crowns	50%	50%	Limited to 1 time per tooth per consecutive 60 months. Re-Cement Inlays/Onlays, Crowns, Brindges and Post and Corre- covered at 80% Alt Benefit – Labial Veneers to be covered at 50%
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments. Occlusal Guard:Covered only if prescribed to control habitual grinding, and limited to 1 guard every consecutive 36 months.
Fixed Partial Dentures (Bridges)	50%	50%	Once per tooth per consecutive 60 months. Include overdenture to be covered at 50%
Implant Services	50%	50%	Limited to 1 time per consecutive 60 months..
ORTHODONTIC SERVICES			
Diagnose or correct misalignment of the teeth or bite	50%	50%	Course of treatment is typically 24 months, with the initial payment at banding of 20% and remaining payment spread over the course of the treatment

This plan includes a roll-over maximum benefit. Some of the unused portion of your annual maximum may be available in future periods.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

**The network percentage of benefits is based on the discounted fees negotiated with the provider.

***The non-network percentage of benefits is based on the usual and customary fees in the geographic areas in which the expenses are incurred.

The Prenatal Dental Care and Oral Cancer Screening programs are covered under this plan.

The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above table provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary of Benefits and your Certificate of Coverage/benefits administrator, the certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental Options PPO Plan is either underwritten or provided by: United HealthCare Insurance Company, Hartford, Connecticut; United HealthCare Insurance Company of New York, Hauppauge, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York or United HealthCare Services, Inc.